

2016 Benefit Comparison— State and Higher Education

PPO services in this table ARE NOT subject to a deductible and costs DO APPLY to the annual out-of-pocket maximum, with the exception of in-network pharmacy, which has a separate out-of-pocket maximum.
CDHP services in this table ARE subject to a deductible with the exception of preventive care and 90-day supply maintenance medications. Costs DO APPLY to the annual out-of-pocket maximum.

COVERED SERVICES	PARTNERSHIP PPO		STANDARD PPO		WELLNESS HEALTHSAVINGS CDHP		HEALTHSAVINGS CDHP	
	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]
PREVENTIVE CARE								
Office Visits <ul style="list-style-type: none"> Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) Adult annual physical exam Annual well-woman exam Immunizations as recommended by CDC Annual hearing and non-refractive vision screening Screenings including colonoscopy, mammogram and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force 	No charge	\$45 copay	No charge	\$50 copay	No charge	40% coinsurance	No charge	50% coinsurance
OUTPATIENT SERVICES								
Primary Care Office Visit <ul style="list-style-type: none"> Family practice, general practice, internal medicine, OB/GYN and pediatrics Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider Including surgery in office setting and initial maternity visit 	\$25 copay	\$45 copay	\$30 copay	\$50 copay	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Specialist Office Visit <ul style="list-style-type: none"> Including surgery in office setting 	\$45 copay	\$70 copay	\$50 copay	\$75 copay	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Behavioral Health and Substance Abuse ^[2]	\$25 copay	\$45 copay	\$30 copay	\$50 copay	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
X-Ray, Lab and Diagnostics <ul style="list-style-type: none"> Including reading, interpretation and results (not including advanced x-rays, scans and imaging) 	100% covered after office copay, if applicable	100% covered up to MAC after office copay, if applicable	100% covered after office copay, if applicable	100% covered up to MAC after office copay, if applicable	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Allergy Injection	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Allergy Injection with Office Visit	\$25 copay primary; \$45 copay specialist	\$45 copay primary; \$70 copay specialist	\$30 copay primary; \$50 copay specialist	\$50 copay primary; \$75 copay specialist	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Chiropractors <ul style="list-style-type: none"> Limit of 50 visits per year 	Visits 1-20: \$25 copay Visits 21-50: \$45 copay	Visits 1-20: \$45 copay Visits 21-50: \$70 copay	Visits 1-20: \$30 copay Visits 21-50: \$50 copay	Visits 1-20: \$50 copay Visits 21-50: \$75 copay	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
PHARMACY								
30-Day Supply	\$5 copay generic; \$35 copay preferred brand; \$85 copay non-preferred	copay plus amount exceeding MAC	\$10 copay generic; \$45 copay preferred brand; \$95 copay non-preferred	copay plus amount exceeding MAC	20% coinsurance	40% coinsurance plus amount exceeding MAC	30% coinsurance	50% coinsurance plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	\$10 copay generic; \$65 copay preferred brand; \$165 copay non-preferred	N/A - no network	\$20 copay generic; \$85 copay preferred brand; \$185 copay non-preferred	N/A - no network	20% coinsurance	N/A - no network	30% coinsurance	N/A - no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) ^[3]	\$5 copay generic; \$30 copay preferred brand; \$160 copay non-preferred	N/A - no network	\$10 copay generic; \$40 copay preferred brand; \$180 copay non-preferred	N/A - no network	10% coinsurance without first having to meet deductible	N/A - no network	20% coinsurance without first having to meet deductible	N/A - no network
CONVENIENCE CLINICS AND URGENT CARE								
Convenience Clinic	\$25 copay	\$45 copay	\$30 copay	\$50 copay	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Urgent Care Facility	\$45 copay	\$70 copay	\$50 copay	\$75 copay	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
EMERGENCY ROOM								
Emergency Room Visit	\$125 copay (services subject to coinsurance may be extra)		\$145 copay (services subject to coinsurance may be extra)		20% coinsurance		30% coinsurance	

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All services in this table ARE subject to a deductible (with the exception of hospice under the PPO options). Eligible expenses DO APPLY to the annual out-of-pocket maximum.

COVERED SERVICES	PARTNERSHIP PPO		STANDARD PPO		WELLNESS HEALTHSAVINGS CDHP		HEALTHSAVINGS CDHP	
	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]
Hospital/Facility Services • Inpatient care; outpatient surgery ^[4] • Inpatient behavioral health and substance abuse ^{[2] [4]}	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Home Care ^[4] • Home health; home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Rehabilitation and Therapy Services • Inpatient ^[4] ; outpatient • Skilled nursing facility ^[4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Ambulance • Air and ground	10% coinsurance		20% coinsurance		20% coinsurance		30% coinsurance	
Hospice Care ^[4] • Through an approved program	100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (after the deductible has been met)		100% covered up to MAC (after the deductible has been met)	
Equipment and Supplies ^[4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Dental • Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	10% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance for oral surgeons	40% coinsurance for oral surgeons	30% coinsurance for oral surgeons	50% coinsurance for oral surgeons
	10% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)		30% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies ^[4] • Reading and interpretation	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	20% coinsurance		30% coinsurance	
Out-of-Country Charges • Non-emergency and non-urgent care	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance	N/A - no network	50% coinsurance
DEDUCTIBLE								
Employee Only	\$450	\$800	\$800	\$1,500	\$1,400	\$2,800	\$1,500	\$3,000
Employee + Child(ren)	\$700	\$1,250	\$1,250	\$2,350	\$2,800	\$5,600	\$3,000	\$6,000
Employee + Spouse	\$900	\$1,600	\$1,600	\$3,000	\$2,800	\$5,600	\$3,000	\$6,000
Employee + Spouse + Child(ren)	\$1,150	\$2,050	\$2,050	\$3,850	\$2,800	\$5,600	\$3,000	\$6,000
OUT-OF-POCKET MAXIMUM								
Employee Only	\$2,300	\$3,500	\$2,600	\$3,900	\$2,300	\$4,600	\$3,800	\$7,600
Employee + Child(ren)	\$3,200	\$4,600	\$3,800	\$5,900	\$4,600	\$9,200	\$7,600	\$15,200
Employee + Spouse	\$3,700	\$5,800	\$4,500	\$7,200	\$4,600	\$9,200	\$7,600	\$15,200
Employee + Spouse + Child(ren)	\$4,600	\$7,500	\$5,200	\$9,500	\$4,600	\$9,200	\$7,600	\$15,200
separate pharmacy out-of-pocket maximum applies	\$2,500 ind; \$5,000 family	none	\$3,000 ind; \$6,000 family	none	included with medical		included with medical	
HEALTH SAVINGS ACCOUNT								
Employer Contribution	N/A		N/A		\$500 individual; \$1,000 family		\$0	

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted. **For PPO Plans**, no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. **For CDHP Plans**, the family amount must be met by the family as a whole. Individual family members may contribute more than the individual amount toward the family total. No one family member may contribute more than \$6,850 to the in-network family out-of-pocket maximum total for the HealthSavings CDHP.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a service from an in-network provider. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization (PA) is required.

[3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)